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	09G136	A. BUILDING _____ B. WING _____	08/10/2007

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WESTVIEW 01	3200 12TH STREET, NE WASHINGTON, DC 20017

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W 000	INITIAL COMMENTS The recertification survey was conducted from August 6, 2007 through August 10, 2007. The survey was initiated using the full survey process. A random sample of three clients was selected from a residential population of two females and four males with mental retardation and other disabilities. A focused review was conducted for one additional client in the area of Client Protections. The survey findings are based on observations in the group home and three day programs in addition to interviews with residential staff, one parent and clients, nursing, and administrative staff. A review of records that included unusual incident reports was also conducted.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Governing Body fail to provide general operating direction over the facility. The findings include: 1. Cross refer to W153 and W156. The Governing Body failed to implement its policy on reporting of injuries of unknown origin timely and to ensure that investigations were reported to the administrator or designated representative with in five working days of the incident. 2. The governing body failed to ensure the	W 104	1. The Governing Body will implement its policy on reporting injuries of unknown origin in a timely manner and ensure that investigations are reported to the administrator or designated representative within five working days of the incident. The Incident Manager will timely report all injuries and investigations to the administrator or designated representative within five working days of the incident. The QMRP will monitor the practices of the Incident Management Coordinator as an incident occurs with oversight by the Administrator.	8.31.07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Fred G. Nash, Jr. M.A. / C. McCall	Administrator	9/4/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 maintenance of the facility's environment, as evidenced by: Environment: a. Client #4's Chester drawer was missing handles. b. Client #6's bedroom ceiling light fixture was missing. c. The closet door in Client #6's bedroom, evidenced a punched out area, with the addition of serveral patched wall surfaces. d. Client #1's family photo frame was broken with mental exposed. e. Client #1's wall push button night light was in operable. f. Upstairs back bathroom (close to fire exit door), bathtub tiles observed budging out from bathtub water facet. Tile molding missing along the baseboard. Window blind damaged (bent) g. Bathroom located in laundry area-grout missing around the tub with some molding. observed. h. Open box of laundry detergent and "elimo" container, sitting on floor, opened. i. Dust noted in all upstairs bedrooms, upstairs bathroom window sills and bedroom air condition vents. Dust noted on baseboards downstairs in main dining room area. j. Sprinkler head in upstairs hallway is missing the metal protector that attaches to the ceiling.	W 104	2. The Governing Body will ensure that the maintenance of the facility's environment is completed through the completion of hounds rounds conducted 3 times a day by each Shift Supervisor. Any maintenance requirements will be reported, in writing on the Maintenance Request Form, to the Environmental Manager. Upon receiving the form, the Environmental Manager will ensure that the requested maintenance is completed within 10 business days. (See Attachment #1) Monitoring of such will be conducted by the Quality Assurance Coordinator during monthly quality assurance review with oversight by the Administrator. a. The handles were replaced on August 24, 2007 and will be checked daily, by the Shift Supervisor, during daily house rounds. b. The ceiling light was replaced in room # 6 on August 20, 2007. All ceiling lights will be checked, by the Shift Supervisor, during daily house rounds.	8-31-07 8-24-07 8-30-07

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W 104	Continued From page 2 k. Entrance foyer light fixture missing. l. Main floor bathroom evidence no shower curtain for privacy, bathroom cabinet (side facing the toilet, evidenced damage). No cup dispenser observed. Seal around toilet is missing. m. Floor tile is broken in upstairs hallway, posing a safety risk. n. Kitchen file door does not seal correctly upon closing. Kitchen Inspection: a. Sink sponges/scrub pads evidence excess usage (worn) with dried food depree. b. Baking cook pans (3 different sizes) surface was scratched with brown rust stains. c. Teflon pot surfaces were scratched off on the inside. d. Bread box surface was sticky to touch. e. Memos posted on cabinets were soiled with water/grease stains. f. Kitchen trash can lid was cracked down the side; dirty. 3. Cross refer to W264. There was no policy and procedure to ensure safety of residents while visitors were entering and exiting the facility.	W 104	c. The closet door in bedroom #6 was repaired and the walls were painted on August 27, 2007. The need for repainting will be monitored by the Quality Assurance Coordinator during monthly quality assuring review with oversight by the Administrator. d. The frame holding the family photos was replaced on August 24, 2007. e. On August 29, 2007, a new light was installed on Client # 1's wall. f. The upstairs back bathroom tiles and molding will be replaced by September 10, 2007. The window blinds were replaced and will be replaced on an as needed basis. g. The bathroom tubs were re-grouted and molding replaced on August 31, 2007. h. All detergent and cleaning agents will be placed in a new closet designed for that purpose. The closet will be purchased by September 10, 2007.	8.27.0 8.24.0 8.29.07 9.10.07 8.31.07
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES	W 120		9.10.07

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W 104	Continued From page 2 k. Entrance foyer light fixture missing. l. Main floor bathroom evidence no shower curtain for privacy, bathroom cabinet (side facing the toilet, evidenced damage). No cup dispenser observed. Seal around toilet is missing. m. Floor tile is broken in upstairs hallway, posing a safety risk. n. Kitchen file door does not seal correctly upon closing. Kitchen Inspection: a. Sink sponges/scrub pads evidence excess usage (worn) with dried food depree. b. Baking cook pans (3 different sizes) surface was scratched with brown rust stains. c. Teflon pot surfaces were scratched off on the inside. d. Bread box surface was sticky to touch. e. Memos posted on cabinets were soiled with water/grease stains. f. Kitchen trash can lid was cracked down the side; dirty. 3. Cross refer to W264. There was no policy and procedure to ensure safety of residents while visitors were entering and exiting the facility.	W 104	I. The new housekeeper will monitor the condition of the entire house on a daily basis making certain that it is free of dirt, dust, or any debris. The Residential Manager will monitor this process during daily house rounds. j. The sprinkler head, upstairs in the hallway, was replaced with a metal protector and will be checked by the housekeeper on a daily basis during house rounds with the Shift Supervisor. k. The light fixture in the entrance was installed on August 29, 2007. All electrical fixtures, plugs, emergency lights, etc. will be closely monitored by the housekeeper during daily rounds. The Quality Assurance Coordinator along with the Environmental Manager will monitor this process. l. On August 30, 2007, a new the shower curtain was purchased, the bathroom cabinet was repaired, the seals around the toilet were, and a new cup holder was purchased.	8.31.07 8.31.07 8.29.07 8.30.07
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES	W 120		

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W 104	Continued From page 2 k. Entrance foyer light fixture missing. l. Main floor bathroom evidence no shower curtain for privacy, bathroom cabinet (side facing the toilet, evidenced damage). No cup dispenser observed. Seal around toilet is missing. m. Floor tile is broken in upstairs hallway, posing a safety risk. n. Kitchen file door does not seal correctly upon closing. Kitchen Inspection: a. Sink sponges/scrub pads evidence excess usage (worn) with dried food depree. b. Baking cook pans (3 different sizes) surface was scratched with brown rust stains. c. Teflon pot surfaces were scratched off on the inside. d. Bread box surface was sticky to touch. e. Memos posted on cabinets were soiled with water/grease stains. f. Kitchen trash can lid was cracked down the side, dirty. 3. Cross refer to W264. There was no policy and procedure to ensure safety of residents while visitors were entering and exiting the facility.	W 104	m. The broken tile in the upstairs hallway will be replaced by September 10, 2007. n. Due to the water content in the paint, the door to the kitchen swelled. The door was shaved and now closes properly. Oil base paint will be used in the future, that will prevent the door from swelling. Kitchen Inspection a. The scrubbing pads will be changed weekly or as needed to eliminate excessive usage and food debris. b. The old baking pans were replaced with iron pans. c. Teflon plans will no longer be used. They have been replaced with iron pans. d. The bread box surface was washed and will be monitored by the Shift Supervisor during daily house rounds and cleaned of any residue, crumbs, or dust.	9.10.07 8.31.07 8.31.07 8.31.07 8.31.07 8.31.07
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES	W 120		

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W 104	Continued From page 2 k. Entrance foyer light fixture missing. l. Main floor bathroom evidence no shower curtain for privacy, bathroom cabinet (side facing the toilet, evidenced damage). No cup dispenser observed. Seal around toilet is missing. m. Floor tile is broken in upstairs hallway, posing a safety risk. n. Kitchen file door does not seal correctly upon closing. Kitchen Inspection: a. Sink sponges/scrub pads evidence excess usage (worn) with dried food depree. b. Baking cook pans (3 different sizes) surface was scratched with brown rust stains. c. Teflon pot surfaces were scratched off on the inside. d. Bread box surface was sticky to touch. e. Memos posted on cabinets were soiled with water/grease stains. f. Kitchen trash can lid was cracked down the side; dirty. 3. Cross refer to W264. There was no policy and procedure to ensure safety of residents while visitors were entering and exiting the facility.	W 104	e. The necessary memos on the board have been replaced with neater appearing ones that were placed in plastic covers to keep therm from getting soiled as time passes. f. A new trash can was purchased and will be monitored daily by each Shift Supervisor, during house rounds, and cleaned daily. 3. See W 264	8-31-07 8-31-07 8-28-07
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES	W 120		

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W 120	Continued From page 3 The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outside services met the needs of one of the three clients (Client #2) included in the sample. The finding includes: 1. The facility failed to ensure the Client #2's day program provided consistent instruction on the usage of her communication device. Observation at Client #2's day program on August 7, 2007, at 12:36 PM, and interview with her classroom support staff revealed that client had a communication device called a "Mini-Merc." According to the staff member, the client received the device on January 24, 2007 (over seven months ago). Further interview revealed that the client did not have any formal learning objectives centered around the utilization of the device. The staff person revealed that Client #2 was currently becoming familiar with the device. The staff person, who was relatively new to the classroom (approximately one month), further revealed that he/she had not received formal training on the device and/or its usage relative to Client #2. At the time of the survey, the facility failed to ensure Client #2 received consistent training on the use of the aforementioned communication device. 2. The facility failed to ensure data was consistently collected on Client #2's formal day program objectives.	W 120	1. The QMRP spoke with the Speech Therapist at Client # 2's day treatment on August 30, 2007 and it was noted that it was an oversight that Client #2 did not have a goal in place to operate her Mini-Merc communication Device. A program was developed, sent to the QMRP via fax, and implementation will begin on September 4, 2007, due to the holiday occurring on the 1st Monday of the month. (See Attachment #2) In the future, the QMRP will ensure that each clients' day treatment program is providing consistent training. The QMRP will conduct monthly visits to ensure that Client #2 and other clients are receiving training in all areas identified at their ISP meetings. 2. The QMRP was unaware that data was not being consistently collected at Client #2's day treatment program. The data collection sheets are sent to the QMRP, on or around the 5th of the following month. In the future, the QMRP will conduct monthly monitoring visits, between the 5th - 10th of the month, to ensure that the data collection has begun.	8.30.0 8.31.07

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W 120	Continued From page 4 Continued review of Client #2's day program record on August 7, 2007, revealed that the client participated with formal program objectives centering around increasing her skills at choice making, setting up/cleaning up after snack, and socialization skills. Interview with the classroom teacher and review of the client's data collection record revealed no data for the month of August 2007. It should be noted that according to the classroom support person, the day program's quality assurance specialist reviewed the data collection records the previous week and informed the classroom teacher that the data was incorrect. Therefore, the staff person revealed that he/she destroyed the data collection records.	W 120		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to establish and implement policies to ensure the health and safety of the clients residing in the facility. The finding includes: The facility failed to implement its Incident Managment Policy. Review of unusual incident reports on August 6, 2007 at approximately 9:30 AM revealed the facility failed to report a total of seven (7) incidents to the Department of Health in accordance with the federal regulations (See	W 149	W 149 In the future, the Incident Management Coordinator will inform all persons involved in the client's care and other officials of all unusual incidents. The QMRP will ensure that the facility's Incident Management Policy is implemented as written with oversight by the Administrator. A copy of the 7 incidents cited in this report is attached for further review by the Department of Health. (See Attachment #3)	8.31.07

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W 149	Continued From page 5 W153). Interview was conducted with the facility's Qualified Mental Retardation Professional (QMRP) on August 6, 2007 to ascertain information about the Incident Management Policy. According to the interview and review of the facility's policy, " The Incident Management Coordinator will immediately call Answers Please to report the incident. After which she will notify via telephone, not necessarily in this order and depending on the severity of the incident, the QMRP, the Residential Manager, the Administrator, any involved family members, the case manager, the attorney, the guardian and the Department of Health."	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of unusual incidents, and review of medical records, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10). The finding includes: On August 6, 2007 at approximately 9:30 AM, the	W 153	The Incident Management Coordinator will report all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source immediately to the Administrator and other officials according to the District Law. The QMRP will ensure that the District Law is implemented by the Incident Management Coordinator with oversight by the Administrator. A copy of the 7 incidents were given to the Administrator for review and a verification signature sheet is attached. (See Attachment #2) A copy of said incidents have also been provided for further review by the Department of Health. (See Attachment # 3)	8-31-07

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W 153	Continued From page 6 facility's unusual incidents were reviewed which revealed a total of seven (7) incidents that were not forwarded to the Department of Health timely as indicated in their Incident Management Policy and procedures. Interview conducted with the Administrator revealed that during the survey review period, the facility had a staffing change in Incident Managers, which resulted in incidents not being forwarded timely. The agency noted the problem and took corrective action.	W 153		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator or designated representative with in five working days of the incident, for one of the six clients (Client #2) residing in the facility. The finding includes: Review of the facility's incident reports on August 6, 2007 at 9:30 AM revealed an incident involving Client #2 dated May 13, 2007. According to the report, Client #2 was observed with a scratch on his nose. Review of the corresponding incident investigation failed to provide evidence that the administrator had been informed of the outcome of the investigation. At the time of the survey, it could not be determined if the results of the aforementioned	W 156	In the future, the Incident QMRP will ensure that the results of each investigation is forwarded to the Administrator by the Incident Management Coordinator, or other designated representative within five working days of the incident. The investigative report regarding Client #2 was forwarded to the Administrator and/or the designated representative for review. A copy of the verification signature (s) of receipt of this investigation report is attached for review by the Department of Health. (See Attachment #3) A copy of the investigation report is attached for further review by the Department of Health. (See Attachment #4)	8.31.07

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W 156	Continued From page 7 investigation was reviewed within the required five working days.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate each client's active treatment. The findings include: 1. The QMRP failed to ensure that Client #2 had a comprehensive psychiatric assessments. [See W214] 2. The QMRP failed to ensure Client #2's special staffing supports and Behavior Support Plans (BSP) had been monitored, integrated, and coordinated to make certain the client received continuous services with the least restrictive measures. Observation and interview on August 6, 2007 at approximately 7:45 AM revealed that Client #2 received one to one staffing support in the residence, 17 hours a day on the weekdays and 24 hours per day on the weekend to address her behaviors. Observation at Client #2's day program on August 7, 2007 at 12:08 PM revealed the client in the lunch room having lunch. The client was furthered observed to	W 159	1. The Psychiatric Assessment for Client # 2 was located and filed accordingly in the Medical Record. (See Attachment # 5) In the future, the Psychiatric Assessment and other reports, will be placed immediately back in the appropriate review after it is reviewed and/or copied by others. The QMRP and the Nursing Coordinator will ensure that all reports are properly filed and available for review by the Department of Health and other officials. The Quality Assurance Coordinator will monitor this process with oversight by the Administrator.	8-31-07

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W 159	Continued From page 8 independently get up from her table and proceed to the restroom alone. Interview with the day program staff revealed the client did not receive one to one staffing supports at the day program. Interview with Client #2's classroom support staff and record review revealed the client had a day program BSP dated June 18, 2007. According to the plan Client #2 exhibited two target behaviors, crying and non-compliance. Review of Client #2's corresponding data collection record however, revealed between the months of January 2007 through June 2007, three incidents of property destruction, two incidents of aggression, two incidents of cursing, one incidents of verbal threatening and one incident of physical threatening had been noted. Interview with the residential staff and review of Client #2's record on August 8, 2007 at 4:40 PM revealed, that Client #2 had a residential BSP dated October 15, 2006. According to that plan, Client #2's target behaviors included; pacing, verbal tantrums, talking to non-existent person, aggression, non-compliance, sexually related behaviors, property destruction, and playing with feces/rectal digging. Further review of Client #2's record revealed the facility conducted monthly psychotropic reviews to ensure the accuracy of the plan and the corresponding medications. It should be noted that interview with the QMRP on August 8, 2007 revealed behaviors exhibited by Client #2 at the day program were not incorporated into the psychotropic medication reviews. Additionally, although Client #2 exhibited similar behaviors at the day program, albeit infrequently, there was no evidence that Client #2's plan had been holistically reviewed/monitored to make certain techniques	W 159	2. The QMRP will ensure that the monthly behavioral data collected at Client # 2's, and other clients as well, day treatment program is reviewed at the monthly Psychotropic Medication Review meeting held in the client's home. As noted Client # 2 has a One to One Paraprofessional at home for 17 hours a day, but one does not accompany her to the day treatment program. When the One to One Paraprofessional services was applied for in 2003, Client # 2 was attending another day treatment provider and there was no indication that a One to One Para-professional was needed at that time. Client # 2 moved into the home at the age of 18, after living with her mother and brother for most if not all of her life. Upon, as suspected, realizing that she was not returning to her natural home behaviors began to be displayed. At the time of her admission to her day treatment program, the need for the One to One Paraprofessional was discussed at the intake meeting. It was agreed, by the team that one was not needed at that time and her adjustment period would be monitored. It was also noted, that her current day treatment program's Administrator	9.11.07

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W 159	Continued From page 9 exhibited to address behaviors in one setting had been thoroughly assessed to ascertain their potential success in all settings. 3. The QMRP failed to ensure the day program met Client #2's needs. [See W120] 4. The QMRP failed to ensure a waste receptacle for used cigarettes was available outside for Client #3. Observation on August 7, 2007 at 6:42 PM revealed Client #3 outside of the facility having a cigarette. After the client finished the cigarette, he was observed to throw the lite cigarette over the fence into the neighbors grass. Further observation of the grounds on the side of the house revealed there were numerous cigarette butts on the ground and in the vicinity in which the client was observed to throw his cigarette. Interview with Client #3 on August 7, 2007 at 6:29 PM indicated that he gets four cigarettes a day. Two of which he smokes at home. Interview conducted with the QMRP on August 10, 2007 at 9:40 AM revealed that an ashtray has been provided for him outside described as large bucket of sand. Observations outside however, failed to provide evidence of the aforementioned bucket. At the time of the survey, the QMRP failed to ensure an appropriate receptacle for discarding cigarettes was maintained for Client #3's use. 5. The QMRP failed to provide evidence that all of Client #2's exhibited behaviors had been addressed. Observation of Client #2 on August 6, 2007 at	W 159	was not in favor or One to One Para-professionals accompanying Client # 2 or any client to the day treatment program. The QMRP consulted with [redacted], Behavior Therapist, at Client # 2's day treatment program regarding this matter. It was noted that this matter would have to be discussed with the day treatment's Administrator, who is out of the country until October. Therefore, the scheduling of a Case Conference is pending at this time. 3. See W 120 , #1 & 2 4. Several waste receptacles to discard used cigarettes were purchased in the past, to be used by Client # 1, but were stolen from the yard. One that can be properly secured, to discourage theft, will be purchased and placed in an appropriate spot in the yard for Client # 3's use and others in need of the receptacle. In the future, the Environmental Manger will ensure that a cigarette/waste receptacle is available at all times for Client # 2. The Quality Assurance Coordinator will monitor the availability of the receptacle on a monthly basis with oversight by the QMRP.	10.31.07 9.30.07

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W 159	Continued From page 10 approximately 6:00 PM revealed the client displayed a behaviors of property destruction (tearing posted documents off of the living room door) and accusing others of hitting her. Interview with Client #2's one to one staff was conducted on August 7, 2007 at 5:50 PM to ascertain information about the client's BSP and targeted behaviors. According to the one to one staff Client #2's behaviors included false accusations. Review of Client #2's BSP dated October 15, 2006 on August 8, 2007 at 4:40 PM however did not include false accusations/accusing others as a targeted behavior. Further review of the plan revealed the target behavior of "accusing" had been discontinued in 2004. At the time of the survey, the QMRP failed to address the reoccurence of this behavior. 6. The QMRP failed to ensure that fire drills were held on each shift quarterly and when problems had been determined, were addressed timely. [See W441 and W448.] 7. The QMRP failed to ensure that all staff were trained in the usage of Crisis Prevention Intervention techniques. At the entrance conference on August 6, 2007, it was communicated that three clients (#2, #5, and #5) all required one to one staffing supports due to behaviors. According to the house manager and staff interview, each of the aforementioned clients, have a restrictive component included in their behavior support plan (physical restraints). According to each individual plan, when a physical/manual restraint is required, only individuals who have been trained in "Crisis	W 159	5. The QMRP consulted with the Psychologist regarding the reoccurrence of Client # 2 false accusations and accusatory behavior. Upon review of the data collection for the past three months, and staff's verbal and written reports, a determination will be made to revise Client # 2's Behavior Support Plan to once again include the aforementioned behaviors. 6. Staff were reinformed of the fire drill schedule and a schedule was posted on the bulletin board for consistent review by staff. (See Attachment # 9) The Fire/Safety Manger will ensure that each Shift Supervisor conducts a fire drill on his/her shift on a quarterly basis according to the scheduled provided. The Quality Assurance Coordinator will monitor this practice with oversight by the QMRP.	9.14.07 8.28.07 8.28.07

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W 159	Continued From page 11 Prevention Intervention" (CPI) are able to perform the restraints. According to the review of the training records on August 9, 2007 at 2:30 PM, all employees had received training on CPI techniques in 2004.	W 159		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client had a comprehensive assessment on file that depicted their current psychiatric status, for one of the three clients (Client #2) included in the sample. The finding includes: Observation and interview on August 6, 2007 at approximately 7:45 AM revealed that Client #2 received one to one staffing support in the residence, 17 hours a day on the weekdays and 24 hours per day on the weekend to address her behaviors. Continued interview and review of Client #2's record on August 8, 2007 at 4:40 PM revealed, the client had a residential Behavior Support Plan dated October 15, 2006. The plan documented "concurrent techniques" which incorporated the use of psychotropic medications. Additional review of Client #2's record on August 8, 2007 at 9:47 AM revealed Physician's Orders (POS) dated August 2007. According to the POS, Client #2 had diagnoses including Impulse Control Disorder. Interview with the Qualified	W 214	See W 159, #1	8-31-07

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W 214	Continued From page 12 Mental Retardation Professional (QMRP) and continued record review on August 8-10, 2007, failed to provide evidence of a comprehensive psychiatric assessment.	W 214		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on observation, and staff interview, the facility failed to review facility practices as it relates to visitors in the home. The finding includes: Throughout the entire survey process (August 6 thru August 10, 2007), staff and visitors were observed entering the group home routinely, without knocking. It was observed that the front door was unlocked the majority of the time, so staff and or visitors could access and exit the group home freely. Around 10:05 AM on August 6, 2007, an unidentified woman and a child entered the facility unannounced and was observed to walk into the kitchen to talk to a staff person. Observation revealed that the visitors were 'familiar" with the staff and the homes layout Through interview	W 264	W 264 Staff were in-serviced on the protection and safety of the home and its residents. (See Attachment #1) Staff were instructed to keep the front and side doors locked at all times. When visitors enter the home, they must remain in the dining area until escorted to a designated visitation area with the person they are visiting, to include visitors of clients, direct care staff, and administrative staff. The staff must have the visitor sign in and out in the visitor's log book. Visitors are not to enter the home after dark, unless prearrangement have been made. This applies to the clients only. Shift Supervisors will ensure that these steps are followed with oversight by the Residential Manager and QMRP.	8.28.07

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W 264	Continued From page 13 later, it was determined that the woman and child were relatives of an employee. Review of the facility's Policy and Procedure Manual on August 6, 2007 at 10:20 AM, failed to evidence employee and visitor expectations upon entering and exiting the facility. The policy and procedure manual did however revealed that the agency had a Safety committee. At the time of the survey, there was no evidence that the facility had reviewed its practices as it relates to entering the clients home and the safety and well being of the clients.	W 264		
W 343	483.460(d)(1) NURSING STAFF Nurses providing services in the facility must have a current license to practice in the State. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that all nurses providing services in the facility had a current license to practice in the District of Columbia. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the personnel files on August 6, 2007 at 2:50 PM and August 10, 2007 at 9:53 AM revealed that some of the professionals' credentials were not available for review. Review of the available records revealed that the facility failed to provide evidence that one Licensed Practical Nurse (LPN) who provided the evening medication administration had a current license to practice in the District of Columbia in accordance with the Health Occupation Revision Act (HORA) Title 3	W 343	Attached is a copy of the license for the LPN cited int his report. (See Attachment #8) In the future, the Human Resource Department will ensure that the records for the LPN, and other consultants, are current, filed accordingly, and available for review by the Department of Health. This process will be monitored by the Quality Assurance Coordinator with oversight by the QMRP and Assistant Administrator.	8.31.07

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W 343	Continued From page 14 Chapter 12 Section 3-1205.13 ("Each licensee shall display the license conspicuously in any and all places of business or employment of the licensee.")	W 343		
W 425	483.470(d)(2) CLIENT BATHROOMS The facility must provide for individual privacy in toilets, bathtubs, and showers. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that Clients be afforded total privacy during bathing and/or toileting for six of six clients residing in the facility. The finding includes: During observations throughout the entire survey, (August 6-August 10, 2007) the bathroom located on the main floor evidenced a wide gap at the bottom of the door (approximately 5 inches) that did not provide for privacy. Interview conducted with the agency administrator and maintenance worker on August 10, 2007 at approximately 11:25 AM revealed that the door was designed to ensure the clients safety in case of a fire and to provide privacy, if and when a client requested toilet paper while in the bathroom.	W 425	The door of the bathroom located on the main floor will be replaced with a properly fitting door that allows for client privacy when in the bathroom. The Environmental Manager will ensure that all doors are proper in size, allow for privacy, and are maintained. The Quality Assurance will monitor the status of all doors during the monthly quality assurance review with oversight by the Administrator.	9.30.07
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		

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W 436	Continued From page 15 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients were trained to use their communication aids, for one of the three clients (Client #2) included in the sample. The finding includes: Observation at Client #2's day program on August 7, 2007, at 12:36 PM, and interview with her classroom support staff revealed that client had a communication device called a "Mini-Merc." According to the staff, Client #2 brings her communication device from home on a daily basis. Observations however, throughout the survey when the client was at her home, failed to provide evidence of the communication device being used. Interview with the Qualified Mental Retardation Professional (QMRP) and record review on August 9, 2007 failed to provide evidence of any formal learning objections designed to train/teach Client #2 how to use her communication device. It should be noted that interview with the day program staff on August 7, 2007 revealed the client had obtained the device in January 2007. At the time of the survey, the facility failed to provide evidence that Client #2 was being taught to use her communication device.	W 436	W 436 As noted, Client # 2 has a Mini Merc communication device, that she carries with her to school. The device was recommended by the Speech Pathologist at Client # 2's day treatment program. The residential's consulting Speech Pathologist is aware of the machine but was not familiar with its use a the time it was obtained. She wanted to familiarize herself within before implementing an objective for Client # 2 that she was unsure how to monitor. After consultation with the QMRP regarding this matter, the residential's Speech Pathologist is becoming familiar with the device in order to develop an appropriate goal and objective. A copy of the goal and objective developed by the Speech Pathologist at the day treatment was provided to the residential's Speech Pathologist for review. Consultation between the two will be conducted in order to develop goals and objectives between the two environments that will maximize Client # 2's use of the machine . The QMRP will ensure that a goal and objective, utilizing the device in the home, is developed for Client # 2 by September 30, 2007.	9.30.07
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by:	W 440		

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W 440	Continued From page 16 Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Review of the fire drill records on August 6, 2007 at approximately 1:50 AM revealed that the facility failed to document a fire drill for each shift from January 2007 through August 2007. At the time of the survey, there was no evidence that evacuation drills were being held on each shift per quarter as required.	W 440	See W159, # 6	8-28-07
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to hold evacuation drills under varied conditions. The finding includes: On August 6, 2007 at approximately 1:50 PM review of fire drill records and interview with support staff and the House Manager revealed that during the past year, staff had not practiced exiting through all three egresses of the facility. Most fire drills were conducted via the front exit. There was no evidence that evacuation drills were being held under varied conditions.	W 441	During the Fire/Safety Training, the staff were instructed to use a different means of egress, out of the three egresses of the facility, other than the front door each time a fire drill is conducted. (See Attachment #4) The Shift Supervisor will ensure that this procedure is followed with oversight by the Fire/Safety Manager.	8-28-07
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents.	W 448		

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W 448	Continued From page 17 This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to address problems which occurred when evacuation drills were held. The finding includes: 1. On August 6, 2007 at 1:50 PM, review of the facility's fire drill evacuation records for the period January 1, 2007 to August 1, 2007 revealed three fire drills that took a long time to evacuate the clients. May 23, 2007-8 minutes and 4 seconds May 4, 2007-7 minutes and April 20, 2007-13 minutes Interview with the direct care staff later that evening revealed that Client #6 has gait difficulties. He requires staffing supports (1:1) and the use of a gait belt for ambulation purposes. The staff stated that if a fire drill happens to occur after he has received his evening medications, he may experience more difficulty with his gait, due to the sedative effect of his medications. Observations of the facility revealed that Client #6's bedroom is located on the 2nd floor of the facility. Although there was evidence that the facility's house manager and/or shift supervisor had been reviewing the fire drill reports, there was no evidence that Client #-6's mode of safe evacuation had been reviewed with the facility's safety/incident committee for further recommendation. 2. Observations throughout the survey process, revealed that the kitchen door, when closed by staff, would not close entirely. The door required	W 448	1. Staff were retrained on how to conduct fire drills and at various times and under various conditions. (See Attachment # 6) Client # 6's bedroom is closes to the side means of egress leading from the second floor. Client # 6's One to One Para-professionals, as well as other staff, were instructed to use this exit when conducting fire drills, especially, when Client # 6 has had his medication and is sedated. The stairs of this egress is also closes to the designated meeting area across the street to the right of the front of the home. The Fire/Safety Manger will contact the Fire Department for training corses on how to safely exit clients with limited mobility from a two story home during a fire drill or a real emergency. The QMRP will ensure that contact is made and a corse/demonstration, if possible, is scheduled with the a fire department representative by September 30, 2007 with oversight by the Administrator. The QMRP will also make contact with Client # 6's DDS Case Manager and the Home and Community Based Services Department for assistance in this matter.	8.28.07

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 448	Continued From page 18 an extra push from staff to close it. Upon closer inspection, it was determined that the kitchen door was a magnetic fire door. A review was completed on the facility's fire drills to determined if this problem had been noted, and had been addressed. Interview with the staff revealed that they did not realize that the kitchen door was a fire door, therefore it had not been reported.	W 448	2. The water content in the paint used on the door caused the door to swell. The door was shaved and now closes properly. In the future, only oil based paint will be used to prevent this from reoccurring. The monitoring for proper closure of all doors will be conducted during the daily house rounds by the Shift Supervisor and Environmental Manger. Oversight will be done by the Quality Assurance Coordinator.	8.31.07
W 449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to investigate all problems which occurred with the evacuation drills and take corrective action. The finding includes: [Cross-refer to W448. 2] The facility failed to ensure that all fire doors functioned successfully during fire drills.	W 449	W449 See W 448	8.31.07
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients received appropriate diets in accordance with	W 460	W 460 The staff person indicated was retrained on the specified diet for Client # 3 and the preparation of the diet. The staff was also instructed to read the labels of seasoning packages for salt content. Those containing salt should not be used when preparing Client # 3's meals. In the future, the Shift Supervisor, who is trained in Food Handlers, will ensure that meals are prepared properly and according to specified diet orders. ((See Attachment # 9) Oversight and retaining will be conducted by the Dietician along with the QMRP, annually and as needed as observed concerns arise.	8.21.07

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W 460	Continued From page 19 their needs for one of the three clients (Client #3) in the sample. The finding includes: At the entrance conference on August 6, 2007 at approximately 9:00 AM, Interview with the House Manager revealed that Client #3 was on a Regular diet, with no added salt, due to hypertension. On August 7, 2007, during the evening meal preparation, staff was observed preparing the raw chicken to be cooked. The person seasoned the meat using a variety of spices. Interview with the cook revealed that Client #3 was on a no added salt diet and the spices used to season the meat consisted of "Ms. Dash" and the spice "adobe". When the cook reviewed the ingredients in the "adobe" seasoning, the first ingredient listed was salt. The cook stated she was not aware that the seasoning contained salt. Review of nutritionist assessement dated November 8, 2006 and the August 2007 Physician Order Sheets (POS) at 10:20 AM revealed that he is prescribed a Regular diet, with no added salt due to chronic Renal Insufficiency and Hypertension.There was no evidence that the group home staff were adhereing to Client #3's prescribed diet.	W 460		

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I 000	INITIAL COMMENTS A re-licensure survey was conducted from August 6, 2007 through August 10, 2007. A random sample of three residents was selected from a residential population of four males and two females with mental retardation and other disabilities. The findings of the survey were based on observations, interviews with residents, one parent, staff, and the review of resident and administrative records including incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. The findings include: Observation and interview with the House Manager (HM) during the environmental walk through on August 6, 2007 and August 10, 2007 beginning revealed the following. Environment: a. Client #4's Chester drawer was missing handles. b. Client #6's bedroom ceiling light fixture was missing.	I 090	a. Client #4's Chester drawer handles were replaced and will be maintained through daily monitoring by the Shift Supervisor during house rounds. b. Client # 6 bedroom ceiling light fixture was replaced and will be maintained through daily monitoring by the Shift supervisor during house rounds. c. The door in Client # 6's bedroom was repaired and will be maintained through daily monitoring by the Shift Supervisor during house rounds. d. Client # 1's family photo frame was replaced and will be maintained through monitoring by the Shift Supervisor during daily house rounds. e. Client # 1's wall push button night light has been removed. A new night light will be purchased by September 10, 2007.	8.31.07 8.31.07 8.31.07 8.31.07 8.31.07

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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I 090	Continued From page 1 c. The closet door in Client #6's bedroom, evidenced a punched out area, with the addition of several patched wall surfaces. d. Client #1's family photo frame was broken with mental exposed. e. Client #1's wall push button night light was in operable. f. Upstairs back bathroom (close to fire exit door), bathtub tiles observed budging out from bathtub water facet. Tile molding missing along the baseboard. Window blind damaged (bent) g. Bathroom located in laundry area-grout missing around the tub with some molding. observed. h. Open box of laundry detergent and "elimo" container, sitting on floor, opened. i. Dust noted in all upstairs bedrooms, upstairs bathroom window sills and bedroom air condition vents. Dust noted on baseboards downstairs in main dining room area. j. Sprinkler head in upstairs hallway is missing the metal protector that attaches to the ceiling. k. Entrance foyer light fixture missing. l. Main floor bathroom evidence no shower curtain for privacy, bathroom cabinet (side facing the toilet, evidenced damage). No cup dispenser observed. Seal around toilet is missing. m. Floor tile is broken in upstairs hallway, posing a safety risk.	I 090	f. The tiles in the bathtub in the back bathroom will be replaced by September 10, 2007. The damaged blinds were replaced, and will be replaced on an as needed basis. g. The bathroom tubs were re-grouted and molding replaced on August 30, 2007. h. A new cabinet will be purchased, specifically for the storage of cleaning agents and detergents by September 10, 2007. The cabinet will be locked accordingly.	9.10.07 8.30.07 9.10.07

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I 090	Continued From page 2 n. Kitchen file door does not seal correctly upon closing. Kitchen Inspection: a. Sink sponges/scrub pads evidence excess usage (worn) with dried food depree. b. Baking cook pans (3 different sizes) surface was scratched with brown rust stains. c. Teflon pot surfaces were scratched off on the inside. d. Bread box surface was sticky to touch. e. Memos posted on cabinets were soiled with water/grease stains. f. Kitchen trash can lid was cracked down the side, dirty.	I 090	i. The newly hired housekeeper will monitor the condition of the home on a daily basis making certain that it is free of dirt, dust, or any debris. The Residential Manager will monitor this process during daily house rounds. j. The sprinkler head in the, upstairs in the hallway, was replaced with a metal protector and will be checked by the housekeeper on a daily basis during house rounds with the Shift Supervisor. k. The light fixture in the entrance foyer was installed on August 29, 2007. All electrical fixtures, plugs, emergency lights, etc. will be closely monitored by the housekeeper during daily house rounds with the Shift Supervisor.	8.31.07 8.31.07 8.29.07
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans. The finding includes: (See Federal Deficiency Report Citation W104,	I 180	l. On August 30, a new shower curtain was purchased, the bathroom cabinet was repaired, the seals around the toilet were repaired, and a new cup dispenser was purchased. m. The floor tile in the upstairs hallway will be replaced by September 10, 2007 to avoid poising a safety risk. n. The kitchen door was repaired and now closes properly.	8.30.07 9.10.07 8.31.07

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I 090	Continued From page 2 n. Kitchen file door does not seal correctly upon closing. Kitchen Inspection: a. Sink sponges/scrub pads evidence excess usage (worn) with dried food depree. b. Baking cook pans (3 different sizes) surface was scratched with brown rust stains. c. Teflon pot surfaces were scratched off on the inside. d. Bread box surface was sticky to touch. e. Memos posted on cabinets were soiled with water/grease stains. f. Kitchen trash can lid was cracked down the side, dirty.	I 090	Kitchen Inspection a. The scrubbing pads will be changed weekly or as needed to eliminate excessive usage and food debris. b. The old baking pans were replaced with iron pans. c. Teflon plans will no longer be used. They have been replaced with iron pans. d. The bread box surface was washed and will be monitored by the Shift Supervisor during daily house rounds and cleaned of any residue, crumbs, or dust. e. The necessary memos on the board have been replaced with neater appearing ones that were placed in plastic covers to keep therm from getting soiled as time passes. f. A new trash can was purchased and will be monitored daily by each Shift Supervisor, during house rounds, and cleaned daily.	8.31.07 8.31.07 8.31.07 8.31.07 8.31.07 8.31.07
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans. The finding includes: (See Federal Deficiency Report Citation W104,	I 180		

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I 180	Continued From page 3 and W159)	I 180	See Federal Deficiency Report Citation W 104 and W 159	
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Interview with Qualified Mental Retardition Professional (QMRP) and review of the personnel records on August 6, 2007 at 2:50 PM and August 10, 2007 at 9:53 AM revealed the GHMRP failed to provide evidence that three staff had the contents of their job descriptions discussed with them at the beginning of their employment and/or annually thereafter.	I 203	The staff cited in this report just completed training and personnel folders, to include signed job descriptions, were not complete and available for review by the Department of Health at the time of survey. The job descriptions for said employees have since been signed and copies are attached for review by the Department of Health. (See Attachment # 11) In the future, job descriptions will be signed immediately at the completion of training, filed accordingly, and reviewed and singed annually by the direct care staff. The complete personnel folders, to include signed job descriptions, will be available for review by the Department of Health and other officials upon entering the home. This practice will be conducted by the Human Resource Department with oversight by the QMRP, Residential Manager, and Shift Supervisors.	8.31.07
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the	I 206		

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I 206	Continued From page 4 GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with Qualified Mental Retardition Professional (QMRP) and review of the personnel records on August 6, 2007 at 2:50 PM and August 10, 2007 at 9:53 AM revealed the facility failed to provide evidence that seventeen (17) staff, two (2) nurses and seven (7) professional consultants had current health certificates on file.	I 206	Health Certificates, for the following employees were obtained and are attached for review by the Department of Health. See Attachment # 12 for S4 See Attachment # 13 for S8 See Attachment # 14 for S9 See Attachment # 15 for S10 See Attachment # 16 for S13 See Attachment # 17 for S18 See Attachment # 18 for S20 See Attachment # 19 for C4 See Attachment # 20 for C7 See Attachment # 21 for C9 See Attachment # 23 for N1	8.31.07
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: Based on Interview and record review, the GHMRP failed to provide evidence of all staffs personnel records. The finding includes: Interview with Qualified Mental Retardition Professional (QMRP) and review of the personnel records on August 6, 2007 at 2:50 PM and August 10, 2007 at 9:53 AM revealed the	I 271		

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I 271	Continued From page 5 GHMRP failed to provide evidence of personnel files for the two direct care staff, and two professional consultants.	I 271	In the future, the Human Resource Department will provide all persons, requesting an application for employment, with a copy of the Westview'Inc.s Health Certification Form that must be filled out by their physician and submitted to the HRD with their completed application packet before being invited for an interview. (See Attachment # 2) Current employees will be given a copy of the form along with a 60 day notification letter from the Human Resource Department informing employee that their Health Certificate is about to expire. Should the employee not submit the completed form as requested and in the time frame requested, said employee will be placed on administrative leave until the information is provided to the Human Resource Department. Review of personnel records will be reviewed on a quarterly basis by the Human Resource Department. This process will be monitored by the QMRP along with the Assistant Administrator.	
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence of licensed professional staff secured by the group home to monitor interventions, in accordance with the goals and objectives of every individual habilitation plan. The finding includes: Interview with Qualified Mental Retardition Professional (QMRP) and review of the personnel records on August 6, 2007 at 2:50 PM and August 10, 2007 at 9:53 AM revealed the GHMRP failed to provide evidence of a current license on file for three professional consultants.	I 391		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS	I 395		

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I 271	Continued From page 5 GHMRP failed to provide evidence of personnel files for the two direct care staff, and two professional consultants.	I 271	The two personnel folders for direct care staff were obtained and a copy is attached for review by the Department of Health.	
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence of licensed professional staff secured by the group home to monitor interventions, in accordance with the goals and objectives of every individual habilitation plan. The finding includes: Interview with Qualified Mental Retardition Professional (QMRP) and review of the personnel records on August 6, 2007 at 2:50 PM and August 10, 2007 at 9:53 AM revealed the GHMRP failed to provide evidence of a current license on file for three professional consultants.	I 391 1391	(See Attachment # 24 for S10) (See Attachment # 25 for S11) In the future, the Human Resource Department will ensure that all employees have a personnel folder in the facility that they work in, is complete, and available for review by the Department of Health and other officials as appropriate. The QMRP and the Assistant Administrator will monitor this process The folder for 2 of 3 said professionals was obtained and a copy is provided for review by the Department of Health. (See Attachment # 26 for C9) The Human Resource Department will request required information to complete new personnel folder for C2 and C8. In the future all personnel chart for staff working in a single location will be kept in a selected location for easy access and availability by the members of the management team to make available at to the Department of Health. The QMRP will monitor this practice with oversight by the Administrator.	
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS	I 395		

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I 395	Continued From page 6 Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure its nurses had current licenses on file. The finding includes: Interview with Qualified Mental Retardition Professional (QMRP) and review of the personnel records on August 6, 2007 at 2:50 PM and August 10, 2007 at 9:53 AM revealed the GHMRP failed to provide evidence of a current license on file for one nurse.	I 395	The license for the nurse cited in this report was ~~unable to be~~ located in time for submission with this report. In the future, all personnel charts for employees working in a single site will be located in a designated storage area and be known to the management team for easy access and availability during annual survey. The QMRP will monitor this process with oversight by the Administrator. See Attachment #8.	8.31.07
I 396	3520.2(f) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals	I 396		

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I 396	Continued From page 7 trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (f) Occupational Therapy; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence that the Occupational Therapist secured by the group home to monitor interventions in accordance with the goals and objectives of every individual habilitation plan, was licensed. The finding includes: Interview with Qualified Mental Retardition Professional (QMRP) and review of the personnel records on August 6, 2007 at 2:50 PM and August 10, 2007 at 9:53 AM revealed the GHMRP failed to provide evidence of a current license on file for two Occupational Therapist.	I 396	The license for the one of the Occupational Therapist was obtained. (See Attachment # 27) In the future, all personnel charts containing required information, will be located in designated storage area and will be known to the management team for easy access and availability during the annual survey. The QMRP will monitor this process with oversight by the Administrator.	8-31-07
I 397	3520.2(g) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (g) Psychology;	I 397	The license for the Psychologist was obtained. (See Attachment # 28) In the future, all personnel charts containing required information, will be located in designated storage area and will be known to the management team for easy access and availability during the annual survey. The QMRP will monitor this process with oversight by the Administrator.	8-31-07

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 397	Continued From page 8 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure its psychologist had current license on file. The finding includes: Interview with Qualified Mental Retardition Professional (QMRP) and review of the personnel records on August 6, 2007 at 2:50 PM and August 10, 2007 at 9:53 AM revealed the GHMRP failed to provide evidence of a current license on file for one psychologist.	I 397		
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence that ensured its Speech and Language Therapist had a valid license on file. The finding includes: Interview with Qualified Mental Retardition	I 399	A current copy of the license for the speech pathologist was obtained and a copy is attached for review by the Department of Health. (See Attachment #28 for C4) In the future, the personnel folders for all staff, to include	8.31.07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G136	A. BUILDING _____ B. WING _____	08/10/2007

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I 399	Continued From page 9 Professional (QMRP) and review of the personnel records on August 6, 2007 at 2:50 PM and August 10, 2007 at 9:53 AM revealed the GHMRP failed to provide evidence of a current license on file for Speech Therapist.	I 399		

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R 000	INITIAL COMMENTS A re-licensure survey was conducted from August 6, 2007 through August 10, 2007. A random sample of three residents was selected from a residential population of four males and two females with mental retardation and other disabilities. The findings of the survey were based on observations, interviews with residents, one parent, staff, and the review of resident and administrative records including incident reports.	R 000		9/5/07
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. The finding includes: Interview with Qualified Mental Retardation Professional (QMRP) and review of the personnel records on August 6, 2007 at 2:50 PM and August 10, 2007 at 9:53 AM revealed the GHMRP failed to provide evidence that ensured criminal background checks were on file and disclosed a seven year history of all the	R 125	Criminal background checks were unable to be obtained for 10 of 11 direct care workers cited in this report, in time to be submitted for review by the Department of Health. A criminal background check is available for S21 and is attached for review. (See Attachment # 1) Criminal background checks for the other 10 will be obtained by September 10, 2007. Should staff not comply with the request they will be placed on administrative leave until a copy of a background check that discloses a seven year history from all jurisdictions where the staff have lived or worked is submitted to the Human Resource Department. The QMRP will monitor this process with oversight from the Administrator. In the future, will make the request for criminal background checks, from a selected investigative agency, for all prospective employees before they are invited to be interviewed. This process will be monitored by the Quality Assurance Coordinator with oversight by the Assistant Administrator and QMRP.	

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R 125	Continued From page 1 jurisdictions where the employee resided and worked for eleven (11) staff members.	R 125		